

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08125

8149

## CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillsboro</b>				c. LENGTH OF STAY IN 1b <b>9 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton - Rural</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS <b>American Corner</b>			
3. NAME OF DECEASED (Type or print) First <b>Lula</b> Middle <b>Versie</b> Last <b>Beauchamp</b>				4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 19, 1883</b>	9. AGE (In years last birthday) yrs. <b>72</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Burton W. Parker</b>				14. MOTHER'S MAIDEN NAME <b>Annabelle Noble</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Milford Kline, Hillsboro, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Breast</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <b>56</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Nov 4</b> , 19 <b>53</b> , to <b>Aug 5</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Aug 1</b> , 19 <b>56</b> , and that death occurred at <b>11:45 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. Paul Knotts M.D.</b>				ADDRESS (Street, city or town, state) <b>Denton Md</b>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) <b>E. Paul Knotts, M.D.</b>				Denton, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 8, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Framptom and Son, Federalburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>8/8/56</b>		24b. REGISTRAR'S SIGNATURE <b>Wm D O'George</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1955 13 AUG

RECEIVED  
JUN 13 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08126

8150

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Henderson</b>		c. LENGTH OF STAY IN 1b <b>63 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Georgiana</b> <b>Bordley</b>		4. DATE OF DEATH Month <b>8</b> Day <b>5</b> Year <b>1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/8/1893</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alacade Wilkerson</b>	
14. MOTHER'S MAIDEN NAME <b>Linda Gibbs</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>220-09-6604</b>		17. INFORMANT <b>Wilmer F. Bordley Henderson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>199.1</b> DUE TO <b>Exhaustion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Abdominal Cramps</b> DUE TO (c) <b>6 mo</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>June 4, 1956</b> , to <b>Aug 4, 1956</b> , that I last saw the deceased alive on <b>8/4</b> , 1956, and that death occurred at <b>1400</b> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>H.F. Silver</b> M.D.		ADDRESS (Street, city or town, state) <b>Goldsboro, Maryland</b> DATE SIGNED <b>8/8/56</b>	
PHYSICIAN'S NAME (Type) <b>H.F. Silver</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8/9/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>	22d. LOCATION (City, town, or county) (State) <b>Near Marydel, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulais</b>		ADDRESS <b>Greensboro, Md.</b>	
24a. REC'D BY REGISTRAR <b>8/10/56</b>		24b. REGISTRAR'S SIGNATURE <b>Al Clark Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

AUG 14 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

09178

Reg. Dist. No. 41

8151

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Caroline</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro, Md.</b>			c. LENGTH OF STAY IN 1b <b>3 mos.</b>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Main Street -- Preston, Md.</b>			d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cherry Nursing Home</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Cecelia Elizabeth Collins</b>			4. DATE OF DEATH <b>August 29, 1956</b>		
5. SEX <b>Fem.</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 11, 1873</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
		Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>seamstress</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Preston, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Simon P. Nichols</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Ann Edgell</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs. Clark Webb Federalsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>June 8, 1956</b> to <b>Aug. 29, 1956</b> , that I last saw the deceased alive on <b>Aug. 29, 1956</b> , and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Charles H. Stonesifer</b> M.D.		ADDRESS (Street, city or town, state) <b>Greensboro, Maryland</b>		DATE SIGNED <b>9/1/56</b>	
PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>8/2/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Linchester Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Preston, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James A. Williams</b>		ADDRESS <b>Federalsburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>9/2/56</b>	
24b. REGISTRAR'S SIGNATURE <b>L. Max Pappin</b>					



# CERTIFICATE OF DEATH

1956

County, State of Maryland  
 Date of Death, 1956  
 Age, 1956

Decedent's Name, John Doe  
 Sex, Male  
 Race, White  
 Date of Birth, 1937

Place of Birth, Baltimore, Maryland  
 Date of Death, 1956  
 Cause of Death, Heart Disease

Signature of Physician, Dr. J. A. Smith  
 Signature of Registrar, J. B. Jones  
 Date of Death, 1956

BUREAU V. S.

SEP 13 1956

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8152

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

081274

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - HUNSON</u>		c. LENGTH OF STAY in 1b —		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EASTON</u> 20-40-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>STATE HIGHWAY</u>			d. STREET ADDRESS <u>2 LOCUST ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLOYD CLEON GEORGE</u>			4. DATE OF DEATH Month Day Year <u>AUG 29 1956</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 8 1922</u> 33 yrs.		9. AGE (In years last birthday) Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER BOTTLED GAS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>JULIUS J. GEORGE</u>			14. MOTHER'S MAIDEN NAME <u>ROSE BIGGER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>220-07-2338</u>		17. INFORMANT <u>JULIUS J. GEORGE, EASTON, MD.</u> Address <u>2 LOCUST ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shock - Multiple Fractures</u> 812X DUE TO (b) <u>Automobile accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Run down by Automobile</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>5:30</u> <u>PM</u> <u>SEP 19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
20f. (City or town) <u>Hunson</u>		20g. (County) <u>Caroline</u>		20h. (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>DAVISON O. GEORGE</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/31/56</u>	
EXAMINER'S NAME (Type) <u>DAVISON O. GEORGE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>SEPT. 1, 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>	
22d. LOCATION (City, town, or county) <u>EASTON</u>		(State) <u>MARYLAND</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. M. Thompson</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Thompson</u>		ADDRESS <u>EASTON, MD.</u>		24a. REC'D BY REGISTRAR <u>SEP 4 1956</u> DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be associated within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS CERTIFICATE OF DEATH

BUREAU V. S.

SEP 4 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8153

## CERTIFICATE OF DEATH

08128

Reg. Dist. No.

66

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RIDGELY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RAILROAD AVE</b>		d. STREET ADDRESS <b>304 FRANKLIN ST.</b>	
3. NAME OF DECEASED (Type or print) <b>ALLEN</b> First <b>WILLIAM</b> Middle <b>KEATING</b> Last		4. DATE OF DEATH <b>AUG. 6</b> 19 <b>56</b> Month Day Year	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 24, 1895</b> 61 yrs.
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>APPAREL INDUSTRY</b>	
11. BIRTHPLACE (State or foreign country) <b>ROCK HALL, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>	
13. FATHER'S NAME <b>SAMUEL TILDEN KEATING</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA SOMERS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>222-01-147</b>	
17. INFORMANT <b>Clenna W. Keating</b> Address <b>DENTON, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>ACUTE CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> 45 years (c) <b>Hypertension</b> 45 years		INTERVAL BETWEEN ONSET AND DEATH <b>10-15 MIN.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) <b>Has been under care of Dr. Thurston Harrison, Easton, Maryland, for 4-5 years.</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> to <b>1956</b> , that I last saw the deceased alive on <b>1956</b> , and that death occurred at <b>3:30 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Charles H. Winacott</b> M.D. ADDRESS (Street, city or town, state) <b>Ridgely, Maryland</b> DATE SIGNED <b>8.6.56</b> PHYSICIAN'S NAME (Type) <b>CHARLES H. WINACOTT</b> <b>RIDGELY, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/9/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARKWOOD CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Kuck</b> ADDRESS <b>5305 Hayford</b>		24a. REC'D BY REGISTRAR <b>DATE 8-7-56</b>	
		24b. REGISTRAR'S SIGNATURE <b>Mary E. Laird</b>	

# CERTIFICATE OF DEATH

1956

BUREAU V. S.

AUG 9 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8154 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08129

Reg. Dist. No. 66

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ridgely</u>		c. LENGTH OF STAY IN 1b <u>78 Yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ridgely</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>			d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Raymond</u> Last <u>Murray</u>			4. DATE OF DEATH Month <u>8</u> Day <u>26</u> Year <u>19 56</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/20/1878</u>		9. AGE (In years last birthday) <u>78</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Tenant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Alexander Murray</u>			14. MOTHER'S MAIDEN NAME <u>Mary Gremmich</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-34-3381</u>		17. INFORMANT <u>Annie Murray</u> Address <u>Ridgely, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 yrs</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Dawson O. George</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/27/56</u>	
EXAMINER'S NAME (Type) <u>DAWSON O. GEORGE MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Henry Burial Ground</u>	
22d. LOCATION (City, town, or county) <u>Ridgely, Maryland</u>		(State) _____			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Bouleis</u>		ADDRESS <u>Greensboro, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>8/28/56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mary E. Laird</u>					

STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS - CERTIFICATE OF DEATH

CLERK

RECEIVED  
AUG 29 1956  
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18** 08158  
**8155 MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Reg. Dist. No. 60

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>New Castle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Henderson</b>	c. LENGTH OF STAY IN 1b <b>8 Hrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark R.D. 2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>		d. STREET ADDRESS <b>None</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>E.</b> Last <b>Webb</b>		4. DATE OF DEATH Month <b>8</b> Day <b>27</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/24/1927</b>
9. AGE (In years last birthday) <b>29</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>7</b>	11. IF UNDER 24 HRS. Hours <b>8</b> Min. <b>15</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist Chrysler Corp/</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Delaware</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Webb 3rd.</b>		14. MOTHER'S MAIDEN NAME <b>Edna P. Cole</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>221-16-0755</b>	
17. INFORMANT <b>Margaret N. Webb</b>		Address <b>Newark, Delaware</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal Injuries - Hemorrhage</b> 910.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Accident</b> DUE TO (c) <b>Accident</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs -</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>LOADING TRUCK WITH LOGS - SEVERE LOG FALL ON LIMB</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>LOADING TRUCK WITH LOGS - SEVERE LOG FALL ON LIMB</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>5</b> p. m. <b>19 56</b>		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>WOODS</b>		20f. (City or town) <b>Rural Henderson</b> (County) <b>Caroline</b> (State) <b>MD</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Dawson O. George</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dawson O. George M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/30/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gracelawn</b>		22d. LOCATION (City, town, or county) (State) <b>Farnhurst, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaie Greensboro, Md.</b>		24a. RECEIVED BY REGISTRAR <b>9/28/56</b>	
		24b. REGISTRAR'S SIGNATURE <b>J. C. Smith</b>	



MISSOURI STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 29 1956

RECEIVED